Clinical Notes and Case Reports

REMOVAL OF OPEN SAFETY-PIN, SIX WEEKS IN INFANT'S HYPOPHARYNX

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THE following report proves that an open safety-pin, 3 cm. long, with an open spread of 2 cm., can lie in the hypopharynx of an infant for six weeks, and that a general anesthetic can be administered and adenoidectomy performed without noticing or dislodging this foreign body:

Baby D., age 6 months, first seen April 7, 1923. Complaint: Fever and tender left cervical swelling of twenty-four hours' duration. History: Difficulty in nursing for several weeks. Gained weight until March 24, when the weight was 16¼ pounds. No food taken from March 24 until March 29. Adenoidectomy under general anesthesia by an ear, nose, and throat specialist on March 29, "to remove the probable cause of the difficulty in nursing."

Present Illness—Fever and cervical swelling for twenty-four hours. Pediatrician wishes ear, nose, and throat excluded as cause of fever.

Physical Examination—Weight 15½ pounds. Temperature 101.2, rectally, at 3 in the afternoon. Small, tender left cervical swelling. Nose normal. Nasopharynx negative to finger palpation. Both membranae tympani normal. Throat normal. Extreme depression and forward traction of tongue brought the loop of a safety-pin into view. Removed with forceps on loop and finger on point.

Subsequent History—Since removal of the safety-pin the mother recalls that a safety-pin was missed February 26, six weeks previous to operation. That evening the child had a choking spell, and whooping cough was suspected. Next day, expectorated material looked like varnish. Mother remembers that the baby stopped cooing about that time.

Convalescence—Temperature, while in hospital, showed moderate elevation for a few days and then returned to normal. The baby again nurses well, coos, and tries to talk.

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THE USE OF CANVAS BELTS IN THE TREATMENT OF FRACTURES OF THE RIBS AND CLAVICLE

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The treatment usually recommended for fractured ribs is immobilization by strapping with adhesive plaster, extending about three-fourths around the chest, applied either from below upward or from above downward at the end of a forced expiration, each strap overlapping the preceding one.

The objections to the use of adhesive plaster are:

1. Often a severe dermatitis forms in a short time after straps are applied, even when strips of gauze are first laid along the straps.

2. After straps are applied, there may be increased swelling, causing more pain and discomfort, and when the swelling decreases the plaster often wrinkles and becomes worthless as a support and it is impossible to remedy the defect without reapplying the plaster.

3. In cases of compound fracture it is often difficult to redress the wound without removal of the plaster.

4. In a serious case reapplication of plaster may become a problem, as removal of old plaster would be very painful and perhaps in some cases impossible on account of the condition of the patient. Even with great care, abrasions of the skin may result and act as avenues of infection.

5. In the event of the necessity of additional radiographs, which may be required from time to time, it would be necessary to remove the plaster, which would be very annoying to the patient and, in addition, may disturb the position of the fragments.

6. Another objection is the impossibility of keeping the skin clean, with the result that the integument becomes macerated and a dermatitis results. This condition is very offensive to the patient, especially in warm weather, and is insanitary. It is also unsatisfactory to the surgeon who takes pride in his work, as the plaster becomes quickly soiled and unsightly.

7. Patients often complain of pain and irritation upon sudden movement of the affected side, due to pulling of the plaster.

8. Plaster often becomes quite expensive when a large amount—sufficient to strap the chest several times—is used. This may become quite a factor, especially in charity work.

9. In applying plaster on female patients it is often difficult to apply straps satisfactorily over the breasts.

10. In cases where the ends of the bone are driven inward, strapping can rarely be done, as there is considerable danger of irritating or compressing the lung. Under these conditions, tight constriction of the chest should be avoided. Tight applications are generally contra-indicated also when the lower ribs are broken.

Emphysema may also follow fracture. In cases of pneumothorax it may be necessary to draw off the air through an aspirating needle or cannula, which could not be readily accomplished if plaster was applied to the chest, without removal of the plaster. In cases of haemothorax, pleurisy, pulmonary congestion or pneumonia, it may be desirable to auscultate the chest from time to time for diagnostic purposes and prognosis.

In view of the foregoing objections, we endeavored to discover some substitute that would afford complete support to the fractured ribs and would be comfortable to the patient. After considerable experimenting we found that the canvas belt, as shown in Figure No. 1, fulfilled these requirements very well.

This belt can be readily made by any dealer in surgical and orthopedic appliances. It can be made of any weight or width desired. The belt is held in place by four straps passed through buckles attached to the opposite edge of the belt. The number of straps may be increased or diminished, as the circumstances require. In order to prevent the belt from slipping down, straps are attached to the upper part of belt in the back and are crossed and carried over the shoulders and through buckles attached to front of belt. By means of these straps the belt can be raised or lowered as desired.

Its use may be extended to include treatment of myalgia, pleurodynia, lumbago, or any other condition requiring rest.

This principle may also be used in cases of sprain of the sacro-iliac joint, the straps being fastened at the lower part of the belt and extending over the perineum.

In discussing the uses of the canvas belt in the treatment of the fracture of the ribs, we wish also to call attention to the application of this principle in the fracture of the clavicle.

Among various methods of treatment suggested by surgical authorities are:

Sayre's dressing of z. o. plaster, Mayor's scarf or sling, posture, plaster of paris, in the abductor method, modified Sayre's, Velpeau, modified Velpeau, recumbent method on a Bradford frame, Moore's figure-eight and clavicle cross.

The same objections to the use of adhesive plaster in

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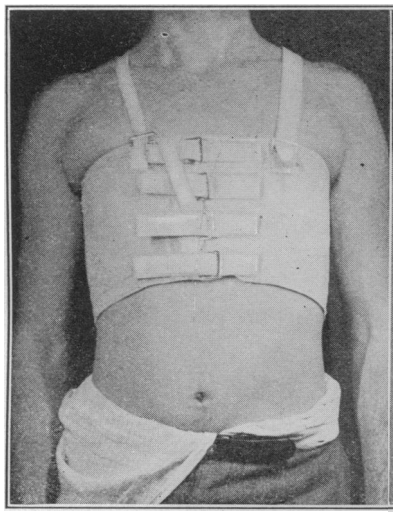

Fig. 1. Use of the canvas belt in the treatment of fracture of the ribs.

Fig. 2. Use in treatment of fracture of the clavicle.

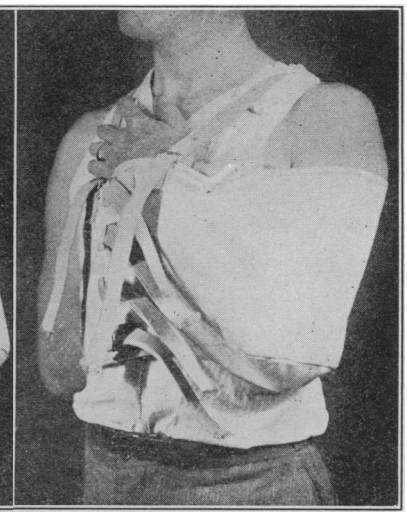

Fig. 3. Use in treatment of fracture of the clavicle with additional strap.

the treatment of fracture of the ribs applies also in the case of the clavicle. With the posture method, very few patients are willing to submit to treatment in bed for the required length of time, as it becomes very irksome, due to the long restraint necessary.

The Velpeau and the modified Velpeau methods of treatment are also often unsatisfactory, as it is frequently necessary to reapply the bandages from time to time, due to the stretching of the bandages, and it is often difficult to keep the turns in place.

Objections are often raised in regard to the figure of eight and clavicular cross, on account of the discomfort while the patient is in the prone position.

This belt is similar to that described for fracture of the ribs, with the addition of a pocket and a flap to support the elbow and forearm.

This appliance is not only useful in the treatment of fracture of the clavicle, but also in fractures of the arm, elbow, and shoulder, in addition to other means of immobilization or any other case requiring support.

In case of fracture of clavicle, with a tendency to displacement, an additional strap is added to top of belt, the end of which is passed through a buckle on front of belt over a pad placed over the fragments. The degree of pressure can be regulated by tightening or loosening strap as desired.

After considerable experience with the use of these belts, we believe that they have many advantages over many of the present methods of immobilization in the treatment of the above injuries. An additional advantage is that they are inexpensive, easily applied, offer a firm support, and can be laundered and repaired as often as desired.

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SPONTANEOUS STRANGULATION OF THE SPERMATIC CORD

REPORT OF A CASE

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Spontaneous mechanical strangulation of the spermatic cord, a comparatively rare condition stimulating both strangulated inguinal hernia and acute epididymitis, has recently been fully described by Thorek in a review of the literature and a report of two cases.

Because of one or two unusual features I wish to report the following case:

C. F. H., male, married, age 31—plasterer. In bed in apparently severe pain. He related that while still in bed he had felt a sudden pain in his right testicle with swelling and radiation of the pain to his abdomen along the course of the cord, and terminating over the external ring. He has had no nausea, or vomiting and his bowels had moved that morning.

At twelve he had mumps, which had descended into his left testicle. He stated that his right testicle had frequently become slightly swollen, but had never pained him and the swelling usually disappeared in a day or so.

Physical examination showed his left testicle atrophied, his right probably once again its usual size, drawn up slightly in the scrotum. There was no redness. The testicle, cord and abdomen were exquisitely tender.

Because of his lack of fever, only moderate swelling without fluctuation, or redness of the scrotum, normal blood count, and open bowels he was placed upon treatment consisting of alternating cold and hot applications, pelvic elevation and codein. This treatment was continued four days and then, because of no change in the condition, operation was insisted upon.

Under ether an incision 10 cm, long was made in the right side of the thickened scrotal wall. A small amount of black blood escaped. The epididymis was greatly enlarged, black and apparently hopelessly gangrenous. The testicle was enlarged to perhaps one-half again its normal size and was dull gray in color. The cord was thickened with definite hard areas just above the testicular attachment, which proved to be the site of the kinking. The contents were delivered free of the scrotum and unkinked of three complete turns from right to left. Under hot applications the black color of the epididymis was relieved and shortly the cord, epididymis and testicle bled freely on puncture. Because of his atrophic left testicle it was felt that it would be wiser to try to save the right and the mesorchium was fastened to the scrotum so a recurrence of the twisting would not be possible. Closure with drainage was made.

Three weeks later it was apparent that in spite of elevation and continuous hot packs the right testicle could not be saved and it, with the epididymis, was removed through high ligation of the cord. Recovery from this operation was uneventful.

Two and one-half months have passed following onset of trouble and patient has not yet been able to demonstrate any function in the atrophic testicle. His weight has increased ten pounds over normal.

Conclusion—A case of spontaneous strangulation of the spermatic cord is added to the literature.

Differentiation from strangulated hernia and epididymitis may not always be easy, although early operation may safely be insisted on in all three conditions.

The cardinal diagnostic points of Thorek are worthy of repetition, namely, sudden onset, extreme tenderness, swelling with no fluctuation, radiation of pain along the cord, normal temperature, and leucocytosis.

Blood vessel strangulation of the cord after seventy-two hours may be partially revived but is exceedingly difficult to maintain. This is in agreement with Thorek.

An atrophic testicle secondary to mumps apparently has resulted in complete loss of function.

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